STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 4.19-B

Supplement 1

State Mississippi

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Pursuant to the provisions of Section 25-14-1, et seq., Mississippi Code of 1972, as Amended, individual providers of medical care under Title XIX are eligible to participate in the Deferred Compensation Plan administered by the Mississippi Public Employees Retirement System Board. The Medicaid fiscal agent defers compensation of individual providers in accordance with the agreement between the provider and the Public Employees Retirement Board. All such deferred payments are made in accordance with State and Federal legal requirements pertaining to deferred compensation plans.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Coverage for Aliens — Payment to a provider who renders a covered service to an alien due to an emergency medical condition shall be at the same rate that is payable for that same service when rendered to any other Medicaid recipient who is not an alien.

TN NO. 87-22 DATE/EFFECTIVE 10-30-87
SUPERSEDES DATE/EFFECTIVE 6-15-90
TN NO. New DATE/EFFECTIVE 10-1-87

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, Mississippi will reimburse for Indian Health Service and Tribal 638 Health Facilities in accordance with the most recent Federal Register notice.

MISSISSIPPI TITLE XIX HOME HEATLH AGENCIES REIMBURSEMENT PLAN

I. Cost Finding and Cost Reporting

A. Each home health agency participating in the Mississippi Medicaid Program will submit a uniform cost report using the appropriate Medicare/Medicaid forms postmarked no later than five (5) calendar months after the close of its cost reporting year. There will be no extensions granted. The year-end adopted for the purpose of this plan shall be the same as for Title XVIII, if applicable. Two (2) completed copies of the cost report, with original signatures, must be submitted to the Division of Medicaid (DOM).

B. Cost reports must be postmarked by the specified due date, unless a waiver is granted by the Executive Director of the Division of Medicaid, in order to avoid a penalty in the amount of $50.00 per day for each day the cost report is delinquent. Cost reports with a due date that falls on a weekend, a State of Mississippi holiday or a federal holiday will be due the following business day.

A home health agency which does not file a cost report within six (6) calendar months after the close of its cost reporting year may be subject to cancellation of its provider agreement at the discretion of the Division of Medicaid, Office of the Governor.

In order for cost reports to be considered complete, the following supplemental schedules must be filed with the cost report:

1. Working Trial Balance (2 copies)
2. Depreciation Schedule (2 copies)
3. Related Party support, i.e., a detailed statement of total costs with adjustments for non-allowable costs and a description of the basis used to allocate the costs, along with a narrative description or a copy of contracts of management services provided by the related party or home office (2 copies); and
4. Medicaid Cost Reporting Schedules, i.e., Medicaid costs and visits by discipline and a schedule to reflect the lower of reasonable costs or customary charges as applicable to Medicaid (2 copies).

C. All home health agencies are required to maintain financial and statistical records. For purposes of this plan, statistical records shall include beneficiaries' medical records. All records must be available upon demand to representatives, employees or contractors of MMC, Mississippi State Department of Audit, General Accounting Office (GAO) or the United States Department of Health, Education and Welfare (HEW).

D. Records of related organizations as defined by 42 CFR 405.427 must be available upon demand to representatives, employees or contractors of MMC, Auditor General, GAO, or HEW.

E. MMC shall retain all uniform cost reports submitted for a period of at least five (5) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60 and Mississippi State Law. Access to submitted cost reports will be in conformity with Mississippi Statutes. Upon request for a copy of any cost report, the home health agency involved will be notified as to why and what is being requested. Unless otherwise advised, the cost report will be released to the requestor 10 days from receipt of the request by the MMC or fiscal agent.

II. Audits

A. Background

Medicaid (Title XIX) and Medicare (Title XVIII) require that home health agencies be reimbursed on a reasonable cost related basis. To assure that payment of reasonable cost is being achieved, a comprehensive audit program has been established.

The common audit program has been established to reduce the cost of auditing submitted cost reports under the above programs and to avoid duplicate auditing efforts. The purpose then is to have one audit which will serve the needs of participating programs reimbursing home health agencies for services rendered.

B. Common Audit Program

The Mississippi Medicaid Commission has entered into agreements with Medicare intermediaries for participation in a common audit program of Titles XVIII and XIX. Under this agreement, the intermediaries shall provide MMC the results of desk reviews and field audits of those agencies, located in Mississippi.

C. Other Audits

For those home health agencies not covered by the common audits agreement with Medicare intermediaries, the fiscal agent for MMC shall be responsible for performance of desk reviews, field reviews and field audits.

D. Retention

All audit reports received from Medicare intermediaries or issued by MMC will be retained for a period of at least five (5) years.

E. Overpayment

Overpayments as determined by desk review or audit will be reimbursable to MMC. All overpayments shall be reported to HEW as required.

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11/19/79 2/1/80

III. Allowable Costs

Allowable costs will be determined using Title XVIII (Medicare) Principles of Reimbursement and the guidelines in the Provider Reimbursement Manual (HIM-15) except as modified by Title XIX of the Act, this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Mississippi Medicaid Program.

A. All items of expense may be included which home health agencies must incur in meeting:

1. The definition of a home health agency to meet the requirements of Section 1901(a)(13) of the Social Security Act.
2. Requirements established by the State Agency responsible for establishing and maintaining health standards.
3. Any other requirements for licensing under the State Law which are necessary for providing home health services.

B. Implicit in any definition of allowable costs is that those costs should not exceed what a prudent and cost conscious buyer pays for a given service or item. If costs are determined to exceed the level that a prudent buyer would incur, then the excess costs would not be reimbursable under the plan.

C. A proportion of costs incurred by a home health agency for services to an eligible Medicaid patient for whom payments are received from third parties are not reimbursable under this plan. Appropriate adjustments shall be made.

D. Cost reports for years ended within a calendar year will be used to establish the class ceilings and home health agency rates beginning the following October 1. For example, cost reports ended during 1996 will be used to compute the rate effective October 1, 1997. The exception will be the costs reports for periods ended in 1995. These cost reports will be used to compute the class ceilings and home health agency rates for a fifteen (15) month period. The 1995 cost reports will be used to compute rates for the period July 1, 1996 through September 30, 1997. This will allow for a transition from a rate year of July 1 through June 30 to a rate year of October 1 through September 30. Providers will be notified of their respective rates by type of visit and rate ceilings by type of visit prior to implementation of the rates. Any provider of home health services under the Medicaid Program may appeal its prospective rates in accordance with Section VI of this Plan.

E. The DOM shall maintain any responses received on the plan, subsequent changes to the plan, or rates for a period of five (5) years from the date of receipt. Such comments shall be available to the public upon request.

F. A home health agency may at times offer to the public new or expanded services or may drop a service. Within sixty (60) days after such an event, the home health agency may submit a budget which shall take into consideration new and expanded services or dropped services. Such budgets will be subject to desk review and audit by the DOM. Upon completion of the desk review, new reimbursement rates will be established. Failure to submit budgets within sixty (60) days shall require disallowance of all expenses, direct and indirect, associated with the service. Overpayments as a result of the differences between budget and actual costs shall be refunded to the DOM. New reimbursement rates shall not exceed the established class ceilings.

G. Type of visit ceilings and individual provider's reimbursement rates will not include amounts representing growth allowances.

H. Payment by type of visit and type of visit ceilings will be established prospectively.

I. The prospectively determined individual home health agency's rate will be adjusted under certain circumstances which are:

1. Administrative errors on the part of the Commission or the agencies that result in erroneous payments. Overpayments or underpayments resulting from errors will be corrected when discovered. Overpayments will be recouped by the DOM and underpayments will be paid to the home health agency. In no case will payment adjustments be made for administrative error or audit findings prior to notifying the appropriate agency and affording an opportunity to present facts and evidence to dispute the exception.

2. The amendment of a previously submitted cost report. Such amendments must be submitted within eighteen (18) months following the close of the cost report period that is being amended. If an increase or decrease in the rate is computed as a result of the amended cost report, claims history will be adjusted retroactive to the effective date of the original rate.

3. The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. At the discretion of the DOM, this shall be grounds to suspend the home health agency from the Mississippi Medicaid Program until such time as an administrative hearing is held, if requested by the home health agency.

4. The home health agency experiences extraordinary circumstances which may include, but are not limited to riot, strike, civil insurrection, earthquakes or flood.

5. Under no circumstances shall such adjustment exceed the class ceiling established for the respective classes.

J. Costs incurred for the acquisition of durable medical equipment and supplies are non-allowable costs since they are reimbursed outside of the home health agency visit rate.

IV. Rate Methodology

A. Prospective Rates. The DOM will utilize a prospective rate of reimbursement and will not make retroactive adjustments except as specified in these regulations. The prospective rates will be determined from cost reports and will be set on a yearly (October 1 - September 30) basis from the date established and will be applicable to all facilities with a valid provider agreement. An exception to this is that rates will be set for fifteen (15) months for the period July 1, 1996 through September 30, 1997. This will allow for a transition to the new rate year due to the change in the due dates of cost reports. Total payments per month for each home health patient may not exceed the average Medicaid nursing facility rate per month as determined based on the nursing facility rates computed at July 1 of each year.

Providers will be paid the lower of their prospective rate as computed in accordance with this plan or their usual and customary charge.

In order to compensate for new or expanded services not accounted for in the reporting year, the home health agency must identify such services no later than each June 30, prior to the start of the October 1 rate determination, and submit financial data in order for a determination to be made of the impact on the cost report.

B. Payment for Home Health Services. Home health services include skilled nursing services, physical therapy services, speech therapy services, home health aide services and medical supplies, equipment, and appliances suitable for use in the home. Payments of medical supplies, equipment, and appliances are reimbursed as described in Section IX, A of this plan.

Prospective rates and ceilings will be established for the home health visits. Services must be provided at the recipient's place of residence on his physician's orders as part of a written plan of care that the physician reviews every sixty (60) days. A recipient's place of residence, for home health services, does not include a hospital, skilled nursing facility, nursing facility, or intermediate care facility except for home health services in an intermediate care facility that are not required to be provided by the facility under federal regulations.

Home health visits reimbursed by this plan include:

1. Skilled Nursing Visit - Nursing services provided by or under the supervision of registered nurses currently licensed in the State of Mississippi. These services must be provided directly by agency staff in accordance with Mississippi State Department of Health, Division of Health Facilities Licensure and Certification standards and in accordance with orders of the patient's physician and under a plan of treatment established by such physician.